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## Health and Well-being

Sam, David L.

Cambridge University Press  
2016

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Sam , D L , Jasinskaja-Lahti , I , Ryder , A G & Hassan , G 2016 , Health and Well-being . in  
D L Sam & J W Berry (eds) , The Cambridge Handbook of Acculturation Psychology, 2nd  
edition . Cambridge Handbooks in Psychology , Cambridge University Press , Cambridge .

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<http://hdl.handle.net/10138/234340>

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## HEALTH

**WORD COUNT 7809** (References excluded)

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### Chapter prepared for

Sam, D.L., & Berry J. W. (Eds). *The Cambridge handbook of acculturation psychology*. 2<sup>nd</sup> Edition. Cambridge: Cambridge University Press

### Accepted author manuscript.

Sam, D. L., Jasinskaja-Lahti, I., Ryder, A., & Hassan, G. (2016). Health. In D. L. Sam, & J. W. Berry (Eds.), *The Cambridge Handbook of Acculturation Psychology*. 2nd edition. Cambridge: Cambridge University Press.

## **ACCULTURATION AND HEALTH**

### **1. Introduction**

Human behaviors are adaptations to eco-cultural contexts (Berry, Poortinga, Breugelmans, Chasiotis & Sam, 2011). What happens to people's adaptation when these change, as occurs during the acculturation process? This chapter focuses on the interrelations between migration, acculturation, and adaptation, emphasizing consequences for health and well-being. The chapter considers both adverse effects on health, as well as resilience in the face of eco-cultural change. We conclude by exploring some clinical implications acculturation may have for practitioners in multicultural settings.

Migration is one major way in which individuals and groups come into first-hand contact with other individuals and groups inhabiting different cultural worlds. As such, much of the chapter will focus on the health of migrants. Unless specifically stated, we are using the term "migrants" as a generic one to refer to all people who migrate; and this encompasses those who do so freely such as sojourners and immigrants as well as those who do so involuntarily like refugees. The impact of migration and acculturation on health has interested researchers and clinicians for years. These interests are however, not limited to the health problems migrants face, but also the risks to society should the migrant place demands on the receiving society's health system. Changes in health following migration have the potential of increasing our understanding of the aetiology of different health problems (Gushulak, Weekers & MacPherson, 2010).

The link between migration and health raises a number of questions, including: whether migrants have poorer health; whether they are predisposed to have poor health; and whether there are some factors in the acculturation process that jeopardize their health. The health of migrants is influenced by many different interacting elements, some anchored to their country of origin, some arising in the society of settlement, and some through the process of acculturation (Gushuluk et al., 2010). Some of these elements can confer risk, whereas others might serve as protective factors. For example, a new society might offer a better health care system and a sense of economic possibility while simultaneously exposing the person to new unhealthy behaviours and diseases, discrimination, and unexpected employment challenges. Moreover, beyond the specific impacts of migration and acculturation, migrants are susceptible to all the other health problems humans face, meaning there is practically no limit to the number and variety of health problems that they can arise.

In striking a balance between the different health problems that can arise, and can be covered in a short chapter, and in clearly communicating unambiguously the complex relationships among migration, acculturation and health we have limited our attention to a couple of infectious (i.e., TB and HIV) and non-communicable diseases (i.e., cancer and CVD), as well as mental health problems (i.e., depression and schizophrenia). For an expanded discussion of different health problems, and practical guidelines for meeting the health challenges of migrants see Pottie , Greenaway, Feightner et al., (2011). Migration is however not a story of compromised health only, but also a story of psychological adaptation and resilience.

This chapter also gives an overview of studies addressing migrants' subjective well-being and factors supporting their capacity to overcome acculturation challenges.

## **2. Some specific health problems and well-being**

### ***Infectious and Non-communicable diseases***

#### **Tuberculosis (TB)**

Tuberculosis (TB) has historically been linked to human migration, where in the early nineteenth century, about a quarter of deaths in Western Europe were attributable to TB. Although Western Europe was responsible for the spread of TB across Asia, Africa and the Americas, the persistence of the disease in Western countries is presently due to the influx of migrants from low-income countries where the burden of TB is still high (Das et al., 2006) and among foreign-born populations settled in Western countries who have an increased risk of developing TB, due to re-activation of latent TB infection contracted in their country of origin (Falzon et al., 2012). Globally, there are more than a billion people with latent TB, which results in over 9 million new active cases and 1.5 million death annually (WHO, 2008)

The TB-bacteria thrives in poverty stricken areas and populations. Not only can migrants potentially bring the disease from countries where it is still common, many new arrivals end up living in conditions that offer little protection from TB. For example, they may live in sub-standard housing and areas characterized by overcrowding and poor sanitation. Recent migrants also tend to underuse the local health system, making them less likely to receive proper medical care following TB infection (see section 5 of this chapter). TB status should be

positioned within the broader framework of all the social determinants that create inequities in a patient's contact with the health services (WHO, 2009).

### HIV and AIDS

In the 30 years or so since HIV/AIDS was identified (in early 1980s), the number of people suffering from the disease and the burden of the disease is still daunting. Globally, an estimated 35.3 million people were living with HIV in 2012 (UNAIDS, 2012), with 2.3 million new cases in 2011. While the number of AIDS-related deaths is presently on decline, the magnitude of HIV/AIDS still calls for global targeting of all possible sources of new instances of the epidemic, among them global travel: as with TB, HIV could only enter an HIV/AIDS-free area via a carrier (Deane, Parkhurst, & Johnston, 2010; Saggurti et al., 2011).

In the early phase of the epidemic, it was not uncommon for countries to consider migrants and other travellers as possible culprits (Jugerns, 2001; Morrison, 2002). Some countries therefore restricted—and some still do—the free movement of people suspected to have HIV/AIDS (see UNAIDS, 2009). It is important however, to distinguish between migration and the behaviour of migrants, as the latter may be responsible for the spread of HIV/AIDS rather than migration per se. It is also important to distinguish between the possible role of long-term immigrants and short-term travellers such as tourists; the latter group, as a result of frequent traveling between places, can readily spread the disease over wider areas. Because of social exclusion and social inequalities in health that migrants experience, there may actually be some positive public health consequences to targeting them as part of HIV/AIDS surveillance.

First, migrants may be exposed to risk because of lack of access to information and to health care. Second, linguistic and cultural difficulties in comprehending prevention and care-related messages make migrants vulnerable to the disease (Haour-Kneipe & Rector, 1996; McMahon & Ward, 2012).

### Cardiovascular diseases (CVD)

Migration and the acculturation process may result in observable changes in lifestyle such as physical activity, eating habits, smoking and use of alcohol, and stress, and these have all been implicated in the development of cardiovascular disease (CVD). Several studies have identified differential rates of CVD among foreign-born and the nationals and these differential rates may be attributed to genetic factors, changes in lifestyle, and some environmental conditions.

Regarding genetics, McKeigue and his colleagues (1993) found that South Asians in the United Kingdom were particularly prone to coronary heart disease. Furthermore both men and women from South Asia had 30-40% higher rates of coronary heart disease than either native British or people from other European backgrounds (Sriskantharajah & Kai, 2007). Similar findings have been found among South Asians in Canada (Sheth, Nair, Nargundkar, Anand, & Yusuf, 1999).

This pattern has been attributed to genetic variations in insulin resistance and glucose resistance, interacting with the local diet (Jolly, Pais & Rihal, 1996; see also Gupta, Singh, & Verma, 2006).

Other studies have stressed the role of environmental factors in the development of CVD. The classical studies in this field from the 1970s (see Kagan, Harris, & Winkelstein, 1974;

Marmot & Syme, 1976) involved comparing rates of heart disease among Japanese immigrants to California and Hawaii to Japanese in Japan. Findings suggest that heart disease prevalence and mortality rates for the subjects in the cohort approach those of settlement society.

Examining changes in CVD among immigrants from 29 countries to Canada, Kliewer (1992) found that mortality rate of immigrants from 26 countries shifted towards the level of the Canadian native born. While not ruling out the possible role of the immigrant's early environment in later CVD, Kliewer's finding also pointed to environmental factors in the host society in the development of CVD. In a more recent study, Koya and Egede (2007) used length of residence in the United States as a crude measure of acculturation and found that longer length of residence in the United States (i.e., >15 years) was associated with increased odds of multiple cardiovascular risk factors, especially obesity, hyperlipidaemia, and cigarette smoking even after adjusting for relevant confounding factors. In the same study, increased residence in the United States was associated with beneficial effects on leisure-time physical activity levels.

### Cancer

Many studies on cancer mortality consider the influence of lifestyle (smoking, drinking and diet), physical environment (solar exposure, air pollution etc.) and predisposition factors such as hereditary factors. The link between certain environmental or genetic risk factors and cancer mortality from specific factors are well documented. In the case of immigrants, studies have focused on changes in their mortality rates following immigration. Some researchers have been testing the *convergence hypothesis* (Kunst et al., 2011; Stirbu et al., 2006; Visser & van



Leeuwen, 2007; Harding et al., 2009; Spallek et al., 2009), whereby the rates of cancer among that of immigrants tend to converge over time towards those of the settlement society. In a literature review, Arnold, Razum and Coebergh (2010) found more all-cancer morbidity among migrants from non-western countries compared with native populations of European host countries. Migrants from non-western countries were more prone to cancers that are related to infections experienced in early life, such as liver, cervical and stomach cancer. In contrast, migrants of non-western origin were less likely to suffer from cancers related to a western lifestyle, e.g. colo-rectal, breast and prostate cancer (Rechel et al., 2013).

### ***Mental health***

Moving to another country is often psychologically demanding and, as such, acculturative stress and its mental health consequences lie at the core of acculturation research. In this section, we briefly look at schizophrenia and depression, which have respectively been described as the most debilitating and the most widespread of all mental illnesses. While both disorders have been implicated in suicide (Baldwin, 2000; Brown et al., 2010), which claims the lives of more than 1 million people each year, their contribution to global burden of disease is often underestimated. This is because mental health problems quite often do not directly result in mortality.

### **Schizophrenia**

In the 1930s, Ødegaard hypothesized that immigrants were liable to have an excess incidence rate of schizophrenia because this disease interferes with its victims attachments to their native community and predisposed them to migrate. Using a group of Norwegian immigrants to the United States and a reference group of Norwegians back at home, Ødegaard (1932) found support for this hypothesis. However, while a number of studies have subsequently found support for the relatively higher incidence of schizophrenia among immigrants compared to natives (e.g., Cantor-Graaf, Pedersen, McNeil & Mortensen, 2003; Cantor-Graae & Selten, 2005) the explanation for these findings has been disputed (see e.g., Bhugra, 2004). Alternatives to Ødegaard's (1932) hypothesis have included: sending countries having high rates of schizophrenia; migration producing stress and elevating rates of schizophrenia; misdiagnosis; differences in symptom presentation; ethnic density in society of settlement; differences in self-concepts and discrepancies in aspirations, and achievement disparity (see Bhugra, 2004, and Hutchinson & Haasen, 2004 for a discussion of these).

Not one of these hypotheses, however, accounts for the differential rates; rather, they appear to interact with one another in complex ways. In a review of European studies on differential rates of schizophrenia among immigrants, Hutchinson and Haasen (2004) highlighted social inequalities, family fragmentation and urban setting as the main reasons for the increased rates of schizophrenia among immigrants, although in some countries where asylum seekers and refugees form the largest group of migrants, the stress of the migratory process are arguably implicated. These may all interact with genetic vulnerability and substance abuse. Moreover, ethnicity and differences in dominant language emerge as major structural

factor in this new epistemology of psychosis and both the causes and the effects on psychopathology may be filtered through an experience of social disadvantage in an urban environment.

### Depression

Unlike schizophrenia, where immigrants appear to have higher prevalence rate than nationals, findings with respect to depression among immigrants compared with nationals are even more inconsistent and contradictory. This may be due to the different measures used which range from the use of un-validated and un-standardized self-reports (e.g., Fandrem, Sam & Roland, 2009), to standardized self-report instruments, to semi-structured and structured clinical interviews (see e.g., Carta, Kovess, Hardoy, Morosini, Murgia, & Carpiniello, 2002; Hovey, 2000). In addition, immigrant samples used in these studies have varied from clinical samples, such as those at outpatient clinics (see e.g., Gutkovich et al., 1999) to samples drawn from the general population or a local community (see e.g., Noh, Wu, Speechloey & Kaspar, 1992). Moreover, not only do immigrant groups differ in their use of health services, the use of these services also varies across countries (Calderón-Larrañaga et al., 2011; Uiters et al., 2009), leading to a cross-cultural clinical bias in sampling.

Contradictory findings with respect to rates of depression among immigrants and nationals have also been observed when similar research instruments have been used among the same group of immigrants in the same country of residence (Rogler, Cortes & Malgady, 1991). Using the Center for Epidemiological Studies Depression Scale (CES-D) in a community-

based study among over 800 adult Korean immigrants in Toronto, the depression rates were not different from rates typical of North American community samples (Noh et al., 1992). By contrast, in another community based study using CES-D among older (mean age 70.6 years) Mexican-Americans in California, the immigrants were found to have higher rates of depression compared to non-Hispanic Caucasians and African-Americans (Gonzales, Haan & Hinton, 2001).

### ***Subjective well-being***

Recent developments in acculturation have shown an increasing interest in self-assessed health status (SAHS) and subjective well-being (SWB) including measures indicative of positive adaptation among immigrants. To bring home the fact that migration and acculturation are not synonymous with poor health, we briefly look at SWB as one form of mental health that directs attention to the positive side of acculturation.

Along with medical conditions as diagnosed by healthcare professionals, measures of SAHS are commonly used in the research on immigrant health and well-being. They have generally been found to correlate with indicators of objective health and to be good predictors of mortality, although the perceptions of what constitutes good or poor health vary by age, socio-economic status (SES) and other characteristics (McDonald & Kennedy, 2004; Pinquart, 2001). The field of SWB focuses, in turn, on people's own satisfaction with and evaluations of their lives, with the most basic of them being related to the moment-to-moment affect that a person feels over time (Lucas & Diener, 2008).

Using a nationally representative sample of 3,000 immigrants with Russian, Kurdish and Somalian background in Finland, Castaneda et al. (2012) found that 85% of Somalis and almost 70 % of Russian-speakers and Kurds reported their health as being good. Among their native Finnish counterparts 80% also reported their health as being good. The Russian (19%) and Kurdish (36 %) immigrants however reported more severe depression and anxiety symptoms than Somalis (9%) and native-born Finns (9 %). As regards life satisfaction, 96 % of Somalian, 83 % of Russian and 74 % of Kurdish immigrants were satisfied with their lives, with the corresponding number among the Finnish reference group being 78 %. These results suggest that while immigrants appear to be psychologically well adjusted, differences exist among the different ethnic and demographic groups when different outcomes are examined.

Studies on developmental patterns of psychological adaptation among immigrants during the course of migration have also yielded conflicting results. Migration has been related positively, negatively, and curvilinearly (U-curve) to subjective health and well-being (for a review, see Rogler, Cortes, & Malgady, 1991). Of particular interest is the U-curve relationship as it has been extensively examined in longitudinal studies. For instance, Tartakovsky (2009a) found in a longitudinal study among adolescent immigrants to Israel that, during the migration process, several indices of well-being (e.g., self-esteem, body image, school competence) decreased in the first year after migration and increased in the third year after migration. Similarly, Mirsky, Baron-Draiman and Kedem (2002) found that a high level of psychological stress among Russian immigrants in Israel persisted for two years. However, in a longitudinal study among the same immigrant population, Lerner, Kertes and Zilber (2005) found that the

level of psychological stress remained high for 5 years. In their cross-sectional study among Russian-Jewish immigrants from the former Soviet Union in the United States, Birman and Trickett (2001) suggested that the crucial period lies between four and five years post-resettlement for adolescent immigrants, and between six and seven years for adult immigrants.

Shen and Takeuchi (2001) reviewed 15 empirical studies conducted in the United States and found no support for the classic U-curve hypothesis. Four studies included in their review failed to find any significant relationship between time and mental health outcomes. The lack of symptoms of distress caused by migration has also been noted in another study among recent immigrants to Israel (Mirsky, Slonim-Nevo, & Rubinstein, 2007). Contemporary thinking suggests that migration-well-being depends on outcomes studied: for example in their study among immigrants from Tonga to New Zealand, Stillman, Gibson, McKenzie, and Rohorua (2014) found that although happiness and self-rated social respect declined, mental health improved. Similarly, Lönnqvist et al. (in press) found among immigrants from Russia to Finland, that whereas immigrants' self-esteem decreased, their life satisfaction increased over the course of migration.

Based on existing empirical evidence, there is no reason to assume that migration necessarily impacts the health and psychological well-being of migrants adversely; rather the relationship between immigration and health is a complex one, where a number of factors may either exacerbate or buffer the stressors inherent in migration. This complex relation is further explored in the next section.

### **3. *Acculturation and health: the link***

To be able to make a reliable conclusion about the health status of immigrants we need to decide with which group to compare migrants. Should migrants be compared with other migrants, their counterparts in the country of emigration, or with the majority group members of the receiving society? In addition, there is an unresolved question of whether immigrants are a select group, and their original health plays a role in their decision to migrate or not, and subsequent health outcome. What are the challenges associated with the reliable assessment of immigrant health status and attempts to improve our theoretical understanding and methodological tools needed to overcome them?

#### ***Healthy immigrant effect***

As can be seen from the overview of studies on immigrant health and well-being presented above, immigrants' health status is often remarkably high considering their impaired socio-economic status in the receiving societies. This phenomenon has been called the healthy migrant effect, which rests on the assumption that healthy people are more likely to successfully migrate. For example, Marmot, Adelstein, and Bulusu (1984) compared the mortality rates of different diseases among migrants from different countries. They found that generally, mortality rates for the migrant groups were much lower than those of residents in the countries of origin. Similarly, Hispanic migrants to the United States have been found to have better health compared to non-Hispanics, in spite of their often precarious socioeconomic situation, and this phenomenon has acquired the term "Hispanic health paradox", and has been

equated to the “the healthy migrant effect” and as the protective effects of Hispanic culture (see Vega & Amaro, 1994).

The ‘healthy immigrant effect’ does not imply that immigrants always over perform the natives/nationals in terms of health. In contrast, it refers to the pattern in which the health of immigrants, in particular, is substantially better than that of comparable native-born people soon after migration, but worsens, and appears to “converge” to the level of the nationals with additional years in the new country (McDonald & Kennedy, 2004). Even though, the healthy immigrant effect has now been documented in several countries, in their review, McDonald and Kennedy (2004) have also noted that the healthy immigrant effect depends, on the health indicator used. Moreover, they point out that the healthy immigrant effect is present for the incidence of chronic conditions, but only weak evidence for self-assessed health status.

There are various explanations for convergence in health outcomes among immigrants with longer residence in a new country (see Hyman, 2001, for an overview). Some of the reasons have been related to the process of acculturation in which immigrants adopt the natives’ ways of living, with others being related to exposure to common environmental factors (Stephen et al., 1994). Moreover, immigrants are said to encounter barriers in their use of health services because of language problems, lack of information about and experience with their new health care system (Leclerc, Jensen, & Biddlecom, 1994; McDonald & Kennedy, 2004).

### ***Pre-migration and adaptation***



A longitudinal design, in which migrants' post-migration well-being is compared with their pre-migration well-being, would help to avert the difficulties involved in finding an appropriate group with which to compare the migrants. Until recently, researchers tended to focus on demographic pre-migration factors, such as age, gender and socio-economic background (for pre-migration trauma see **Chapter X**). In contrast, studies including both pre- and post-migration assessments of health and psychological well-being are difficult to find.. Pre- and post-migration assessments of well-being were included in studies by Tartakovsky (2007; 2008; 2009a; 2009b) among high-school adolescents immigrating from Russia or Ukraine to Israel and by Jasinskaja-Lahti and colleagues (Jasinskaja-Lahti & Yijälä, 2011; Mähönen & Jasinskaja-Lahti, 2013) among immigrants from Russia to Finland. These studies demonstrate that post-migration well-being of immigrants is highly predetermined by pre-migration health and well-being.

However, the importance of pre-migration assessments is not limited to baseline assessment of psychological well-being. During the pre-migration stage, immigrants often start to prepare towards an upcoming migration by developing particular patterns of identities, attitudes and behaviours as well as by anticipating and preparing for future post-migration adaptation and intergroup interactions (e.g., Jasinskaja-Lahti & Yijälä, 2011). Thus, there is a need to better study the prerequisites of acculturation in the so-called action stage of the pre-migration period (Tabor & Milfont, 2011). Jasinskaja-Lahti and Yijälä (2011) have suggested that this action stage is characterized by a process of pre-acculturation resulting from the direct

and indirect contact with the destination country prior to emigration, with subsequent changes in a potential migrant's cultural, emotional, attitudinal, and behavioral patterns.

There is also the need to better understand the interplay between immigrants' pre-migration experiences and expectations and post-migration experiences in shaping psychological adaptation after migration. Indeed, accurate expectations of one's future migration may decrease uncertainty related to the decision to move (Black, 1992), as well as strengthen stress-coping skills in dealing with stressful situations (Ward, Bochner, & Furnham, 2001) and help adjustment after migration (Bürgelt, Morgan, & Pernice, 2008; Mähönen & Jasinskaja-Lahti, 2013). Expectations can thus eventually become self-fulfilling prophecies (Shelton & Richeson, 2006), although there can also be *"a mismatch between expectations and reality"* (Ward et al., 2001, p. 76), leading to lower satisfaction.

Potential migrants may have specific expectations related to different areas of their post-migration adaptation including their anticipations of socio-cultural difficulties (e.g., language difficulties, finding friends, adjustment to different values and norms), economic situation (e.g., job prospects and financial security) and intergroup relations (e.g., quality of contact with majority group members, prevalence of discrimination). Mähönen, Leinonen, and Jasinskaja-Lahti (2012) noted, for example, that migrants' expectations, experiences, and interrelationships in the economic domain did not affect psychological outcomes after migration. In the social domain, by contrast, the more expectations were exceeded by actual experiences, the better were life satisfaction and the general mood of migrants.

### ***Acculturation Orientations***

In the post-migration stage, the independent role of the receiving context and attitudes of both immigrants and members of the receiving society in the psychological adaptation of immigrants cannot be overemphasized. Acculturation research has focused on acculturation orientations, and in particular on *acculturation attitudes* or *acculturation strategies* of migrants (see Chapter 2 of this volume) as predictors of their adaptation outcomes. In particular, the benefits of the integration strategy (i.e., the combination of a positive attitude both towards maintenance of cultural heritage and towards contact with the host society) have been generally attested (Berry et al., 2006; Nguyen & Martinez-Benet, 2013)

The Interactive Acculturation Model (IAM) by Bourhis and his colleagues (1997), points to how migration experience is also powerfully shaped by the acculturation preferences of the majority group members. Jasinskaja-Lahti, Liebkind, Horenczyk and Schmitz (2003) examined whether the acculturation orientations of repatriates from the former Soviet Union to Finland, Germany and Israel and those of the nationals were concordant or discordant, and whether the concordant vs. discordant profiles were related to perceived discrimination and acculturation stress. Their results indicate that immigrants whose personal acculturation preferences were most in conflict with those of the majority group either perceived more discrimination or reported more stress than other immigrants.

Along with acculturation strategies, consistent and robust finding is that *prejudice* and *discrimination* have direct, strong and long-lasting impact on psychological well-being and health (for a review of population-based studies on the relationship between perceived ethnic

discrimination and well-being see, e.g., Williams, Neighbors, & Jackson, 2003). In the most recent meta-analysis by Schmitt, Branscombe, Postmes, and Garcia (2014) found that perceived discrimination caused substantial harm, particularly for the well-being of members of disadvantaged groups (e.g., ethnic minorities and immigrants), children and for those with more personal than group-based experiences of discrimination. Longitudinal studies in real-life immigration contexts (e.g., Jasinskaja-Lahti, 2008; Jasinskaja-Lahti, Liebkind, & Solheim, 2009), have also shown that psychological well-being among immigrants may be less determined by the absolute level of discrimination experienced in the past than by an increase in discrimination over time. In addition, a high level of psychological stress experienced at an early stage of acculturation increases vulnerability not only for subsequent psychological maladjustment, but also for long-term exposure to and/or perceptions of ethnic discrimination, showing the reciprocity of the link between perceived discrimination and well-being link.

#### **4. Resilience**

Acculturation processes can potentially have all kinds of negative implications for a person's health. Yet, it is equally clear that many people nonetheless do comparatively well. In spite of stressors, individual do not get particularly sick; they surmount obstacles; they even come to flourish in this new environment. Over the past two decades, health researchers have invoked the concept of *resilience* to help explain why people who have undergone broadly similar experiences can nonetheless have very different outcomes. While there is no consensus definition, resilience can be broadly understood as, "a pattern over time, characterized by good

eventual adaptation despite developmental risks, acute stressors, or chronic adversity.”

(Masten, 1994, p. 5)

Given the high degree to which cultural context shapes normal development, likelihood of encountering particular adverse events, the extent to which a life stressor is ‘normal’, or the ways in which one is expected to contribute to the community, resilience needs to be understood in relation to local norms (Masten & Powell, 2003; Ruiz-Casares et al., 2014). These norms are by definition in flux when acculturation processes are underway, complicating the issue of how best to think about resilience to acculturative stressors. The standard view of resilience in the literature, moreover, is shaped by ‘Western’ cultural norms: the resilient person is one who is able to face adversity alone; a view of high functioning that may not fit well with other cultural contexts (Cohler, Stott, & Musick, 1995).

Culture also interacts with mind and brain in complex ways, so that resilience, vulnerability, risk etc., might be better understood as system properties rather than individual characteristics (Chentsova-Dutton & Ryder, 2013). For example, a number of studies now suggest that the same gene might confer vulnerability or resilience depending on the environment—and similar environments might confer vulnerability or resilience depending on specific genes (e.g., Bakermans-Kranenburg & van IJzendoorn, 2007; Belsky et al., 2009; Schmidt et al., 2009). Specific alleles can confer resilience to depression, use of emotional suppression, or willingness to seek social support in one cultural context, while leading to particular vulnerabilities in another (Chiao & Belinsky, 2010; Kim et al., 2010, 2011).

There are, nonetheless, some tentative statements that can be made about the characteristics and circumstances of resilient people and resilient groups experiencing acculturation. Space does not permit a comprehensive review of this literature; we limit ourselves therefore to some intriguing findings. Specifically, we focus on individual characteristics of resilient (and vulnerable) people undergoing acculturation, considering some key findings as well as highlighting the limitations of this approach; and the specific circumstances that people encounter during the acculturation process that might influence the degree to which their trajectory is characterized by resilience.

### ***Individual Characteristics***

Age and gender are key socio-demographic factors associated with health and well-being. For instance, immigrant women report more psychological problems (e.g., anxiety and depression), while immigrant men report more behavioural and addiction problems (Berry et al., 2006; Liebkind & Jasinskaja-Lahti, 2000; Rahav, Hasin & Paykin, 1999). The importance of SES is also well-documented: common mental disorders occur more frequently in socially disadvantaged populations (e.g., Fryers, Melzer, & Jenkins, 2003), including immigrants and ethnic minority group members (Chou, 2009; Kessler, Mickelson, & Williams, 1999). In post-migration studies, low SES is often even more predictive for health among ethnic minorities than other acculturation variables (e.g., Rudmin, 2009).

There are also major *individual differences* in how people deal with the stresses of migration. Certain dispositional characteristics confer broad resilience to a range of mental

health problems, most prominent among these being emotional stability (i.e., the low pole of the personality trait of Neuroticism), extraversion, and secure attachment. All of these characteristics have been generally considered beneficial for well-being, including the context of migration (Bakker, Van Oudenhoven, & Van der Zee, 2004; Schmitz, 2004; Ward, Leong, & Low, 2004). Emotional stability has, for instance, been associated with lower levels of depression, anxiety, somatic symptom reports, and non-specific health complaints (Lahey, 2009). Not surprisingly, emotional stability is also associated with lower levels of acculturative stress (Mangold, Veraza, Kinkler, & Kinney, 2007; Ramdhane, 2012). Optimism, sense of control, and self-efficacy are similarly associated with less psychological stress and homesickness in immigrants (e.g., Bürgelt et al., 2008; Chou, 2009; Tartakovsky, 2009a).

Despite this powerful and general effect of individual characteristics, acculturation-specific factors predict significant additional variance on health outcomes (e.g., Chen, Benét-Martinez, & Bond, 2008; Ryder, Alden, & Paulhus, 2000). Thus, as has already been noted with respect to identity and acculturation (see Chapter 3 of this volume), and in many contexts, bicultural identity and competence in both heritage and mainstream cultural contexts is the most beneficial in terms of resilience (see Berry et al., 2006; Nguyen & Benet-Martinez, 2013). Recent research has suggested that the degree to which integration is beneficial depends on *how* the heritage and mainstream identities are integrated. For example, Mainland Chinese immigrants to Hong Kong benefit from integration when heritage (Mainland Chinese) and mainstream (Hong Kong) identities are experienced as harmonious, but less so when they are experienced as conflictual (Chen et al., 2008).

Integration, particularly harmonious integration, may lead to certain mental health benefits, but the degree of resilience conferred also depends on the specific health issue, and the relevant health practices in both heritage and mainstream societies. Immigrant youth in Norway who were less engaged with the mainstream cultural context were also less likely to smoke or to drink alcohol, but they were also less likely to use safety devices such as bicycle helmets (Sam, 1994; Thuen & Sam, 1994). Latino data from the representative 1991 National Health Interview Survey in the United States showed that engagement with the mainstream cultural context was associated with increased rates of smoking, alcohol intake, and obesity, but also increased rates of exercise (Abraído-Lanza et al., 2005).

### ***Social context***

The degree to which resilience is primarily conferred by cultural maintenance (e.g., Asvat & Malcarne, 2008), assimilation to the mainstream culture (e.g., Zhang, Mandl, & Wang, 2010) or integration (e.g., Berry, et al., 2006) depends on contextual factors. For example, as discussed earlier in this chapter, the impact of a migrant's acculturation strategies depends greatly on the extent to which they are valued or devalued by the receiving society (Bourhis et al., 1997; Kunst & Sam in press). Indeed, where there is marked discrimination (as a result of devaluation) separation, rather than integration may be the source of resilience (Jasinskaja-Lahti et al., 2009, 2012; Schwartz et al., 2010).

Clearly there are limits to the extent that general claims can be made about the overall resilience conferred by individual differences in acculturation, in the absence of information



about the specific heritage and mainstream cultural contexts. Rather than focusing solely on individual differences that confer resilience in general, it may perhaps be better to focus on how social context interacts with individual characteristics to confer resilience. Doing so would fit with a turn in recent years back towards social ecological variables in social and cultural psychology (Jurcik et al., in press; Oishi & Graham, 2010; Oishi, Kesebir, & Snyder, 2009)

Social support, which benefits a person's well-being in general (e.g., Cohen & Wills, 1985; Komproe, Rijken, Ros, Winnubst, & Hart, 1997) and immigrants' adjustment in particular (e.g., Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006; Ryan et al., 2006; Shen & Takeuchi, 2001; Vega, Kolody, Valle, Weir, & Bohdan, 1991) are two such areas to look at. Chou's (2009) study not only showed that immigrants reporting lower levels of social support were more likely to report high levels of depressive symptoms, it also demonstrated that social support buffered the harmful effects of poor migration planning.

In addition, the support provided by ethnic community may buffer the negative effects of perceived discrimination on well-being. Those researchers combining social-psychological and acculturation perspectives on immigrants' well-being have utilized the Rejection-Identification Model (RIM, Branscombe et al., 1999; Schmitt & Branscombe, 2002) and shown that perceived discrimination increases minority group members' identification with their own group, which, in turn, ensures supportive relationships with ethnic community, further fostering psychological well-being (PROVIDE REFERENCE).

The link between identification, supportive ingroup relationships, and resilience may depend on the proportion of co-nationals in the migrant's new community (e.g., Murphy,

1973)—the so-called ‘ethnic density effect’. South East Asian refugees in Canada of Chinese heritage showed more resilience in the early years of resettlement due to their access to local Chinatowns (Beiser, 1999). High heritage acculturation predicted greater alienation in Russian migrants in Chicago, but this relation was attenuated when people lived in neighborhoods with a high concentration of migrants (Miller et al., 2009). High mainstream acculturation predicted more depression in Hispanic older adults, and this relation was exacerbated in neighborhoods with a low density of Hispanic residents.

Finally, high heritage acculturation predicted less psychosocial distress in high ethnic density neighborhoods, but less psychosocial distress in low ethnic density neighborhoods, in a heterogeneous immigrant sample and a community sample of recent Russian migrants, both in Montreal (Jurcik et al., 2013, Jurcik et al., in press). More established Russian migrants, in contrast, showed a negative relation between heritage acculturation and psychosocial distress in low ethnic density neighborhoods, and no such relation in high ethnic density neighborhoods. These studies provide early evidence that individual differences, community characteristics, and demographic variables all interact to predict resilience.

## **5. Clinical Implications**

### ***Barriers to help/treatment-seeking among migrants***

In the context of services to migrants, barriers to accessing care are complex and multiple involving legal, contextual, economic, and religious/cultural factors (Hassan et al., 2011). Legal barriers include fear of losing sponsorship agreements, risks of deportation, or losing access to

potential citizenship if significant physical or mental health problems are disclosed. These fears constitute a major barrier to disclosure and seem to stem from migrants' lack of knowledge on their rights and obligations and the way they may relate, or not, to their migratory status.

Legal and economic barriers are also located in the larger legislative, social and economic dynamics of phenomena such as globalization and migration (Detlaff, 2009). For example, significant disparities for most vulnerable immigrant populations exist, largely due to eligibility rules that exclude asylum-seekers, undocumented and refugees from accessing care (Capps et al., 2004). Migrants may also lack knowledge about services available to them and the paths to access these services. In parallel, practitioners may lack knowledge about vulnerability factors within the migrant communities they service, and about means to access the most vulnerable or at risk families/individuals.

The linguistic barrier is often reported as the major concern among patients and health practitioners alike as it significantly alters the process of meaning making. Patients who do not speak the language of the host society—or do not speak it fluently enough—may not be able to convey the nature of their suffering to their practitioners (Segalowitz & Kehaiya, 2011). The use of interpreters and cultural brokers is thus strongly recommended in order to provide the patient with the option to navigate between their mother-tongue and the clinician's language in communicating their difficulties. Use of interpreters however poses significant challenges that practitioners must be aware of in order to optimise the practitioner-interpreter collaboration (Leanza, Miklavcic, Boivin, & Rosenberg, 2013).

An added complication is that explanatory models of illness and idioms of distress (i.e., etiology, symptoms, treatment and outcome) vary markedly across cultural contexts and are further influenced by migration and settlement conditions (e.g., Kirmayer, 2007; Kleinman, 1988; López & Guarnaccia, 2000). The first barrier for help-seeking and accessing care may thus stem from the differences in identifying whether the person actually does suffer from a health problem and in understanding its nature, and accurately interpreting the meanings of displayed “symptoms” and the treatments that make sense for the patient (Kirmayer, 2012; Ryder & Chentsova-Dutton, in press).

Persons from diverse migratory contexts may additionally hold a negative view of Western health services, particularly mental health services (Hassan et al., in press). Their apprehension may stem not only from stigma related to certain physical or mental illnesses, but also from their past experiences with the health systems in their country of origin as well as in their current context (Hassan et al., 2012; in press). Vulnerable immigrant, refugee and asylum-seeking families, who may have been persecuted by different institutions who have power in their country of origin, may view practitioners with suspicion (Kohli, 2006b), may fear punitive institutional power (Pottie et al., 2011; Hassan et al., 2011), and may experience the intervention as deficiency focused thus questioning their worth and competence (Hassan et al., 2011).

Immigrant communities may also be particularly vulnerable to stigma related to mental health (less so for physical health). Stigma generally stems from the fear of scandal and shame, which result from the labelling of psychological or physical suffering as “pathologies” or

“mental disorders” (Hassan et al., in press; [CITE Ritsher, Link](#)). Such labelling may cast shame on the patient and his/her family and compromise his/her reputation or social status (Cifci, Jones, & Corrigan, 2012), and consequently compromise the use of services and commitment to treatment (Lin, Inui, Kleinman, & Womack, 1982). Some immigrant communities may perceive illness as a private family matter to be resolved within the family or the community and may thus be resistant to seek professional help, or may do so as a last resort, often when the situation has become highly problematic (Ryder, Bean, & Dion, 2000).

In order to alleviate the impact of these barriers, the intervention plan should include an advocacy component. Advocacy must directly address settlement conditions that constitute detrimental risk factors (Detlaff, 2009) (help with reading and understanding legal documents, preparing papers, legal procedures, etc.), isolation and poverty (finding cheap clothing, reducing bills, etc.). Professionals may provide patients and their families with information about relevant laws, their rights and responsibilities in terms of immigration status, and availability of services geared towards migrants. This information should be provided in the appropriate language if at all possible (Boiko, Katon et al. 2005; Crandall 2005; Dutton 2000).

### ***Assessment and treatment challenges***

The comparison of the immigrant patient to the norms established on the basis of a specific reference population (from which that person does not originate) poses significant methodological as well as ethical issues, because by default, the individual is situated outside of the standard norm of reference (Le Du, 2009). To be valid, the immigrant patient must be

compared to the norms established for the reference group to which s/he belongs. The tendency to overestimate the hypotheses generated by psychometric tests is directly derived from the perception—highly prevalent in Western institutions—that psychological phenomena are now identifiable, predictable and preventable primarily through the application of western psychometric approaches and standards of care (Connolly, Crichton-Hill & Ward, 2006; Parton, Thorpe & Wattam, 1997, CITE Hassan, Rousseau, 2008).

Moreau et al. (2011) have, for instance, shown how cultural and migratory contexts significantly influence the meaning of some symptoms and behaviours, which in turn the validity of symptom scales and the validity of the entire syndrome. Item-analyses of the SCL-25 showed that the item *“I feel that everything requires a lot of effort”* was not at all understood as a symptom of depression, but was positively perceived by immigrants as a sign of success in the host country (Moreau et al., 2010). There is no simple answer to these challenges, although a good beginning would be to consistently remind practitioners that they cannot formulate a clinical diagnosis in a cultural, social and economic vacuum (Coles et Veiel, 2001).

Psychometric tests can be used as diagnostic tools, but also as “cultural’ tools—as gateways for exploring the cultural world of the subject. To do so, the practitioner may use the “complementarity approach” (Devreux, YEAR??? PROVIDE FULL REFERENCE..) which requires the use of independent levels of analysis: the first being a psychological and individual level and the other an anthropological and cultural one (Le Du, 2009). The objective of this method is to try to recognise the uniqueness of the individual but on the background of his/her cultural

affiliations (Le Du, 2009, p. 137), as well as the social/economic forces that shape his/her daily life.

The concept of dys-normativity brings out the gap between the norms of the majority cultural group and those of certain migrant families who may display behaviors that are considered outside the norms of the dominant social context. Such behaviors can be erroneously interpreted as dysfunctional (Mosby Rawls, Meehan, Mays & Pettinari, 1999). The principle of dys-normativity may also help explain why certain migrant families may be over- or under-represented in health institutions and are subjected to differential health practices. The practitioner decontextualizes when he or she assumes the universality of psychological processes and contents related to health and illness. Indeed, how cultural contexts that deviate from the majority are viewed from the outside is filtered through the lens of power relationships and ethnocentrism (Maitra, 1995; Graham, 2002; Brophy et al., 2003; Thompson, 2003). In multicultural clinical settings, de-contextualization can be observed in the use of "recipes"—an approach to cultural competence that inscribes the main responsibility for suffering and healing to the cultural characteristics of the patient.

Beyond the basics of any competent intervention, specific aspects need to be taken into consideration in multicultural settings in order to 're-contextualize' the patient. Some knowledge about the country of origin can be helpful, including details such as: colonial history; geography and location; political and social structures; religious dynamics; conflicts and violence; family relationships; and racial constructs and relationships (Lashley

et al., 2013). That said, although the acquisition of knowledge is useful, practitioners must be also be wary of perpetuating stereotypes and rigid categories. Stereotypical representations can lead clinicians to interpret the patients' symptoms through the conceptual lenses of the dominant cultural context (Lashley et al., 2013). This approach in turn often leads to clinical recommendations that aim to re-establish the conditions for well-being as defined by dominant group (Maitra, 2012).

Gaining knowledge of the origin of the patient must instead serve as a doorway to establishing rapport and getting to know migrant patients and their families through history-taking—including information about country of origin, migration history, generation, acculturation, adherence to culture of origin, ethnic and multicultural identity, SES, family experiences after settlement in host country, level of bilingualism, understanding of culturally congruent and incongruent behaviors—a process at the very heart of effective care (Hus et al., 2001; Chan, 1992; Ho, 1990; Heras, 1992; Lee, 1996; Hassan et al., 2011; Pottie et al., 2011; Ryder & Chentsova-Dutton, in press). In addition to content, the process of clinical intervention needs to be considered in a culturally sensitive way. For example, practitioners must not pressure patients to express emotions or disclose in a culturally unfamiliar manner, as cultural expectations may prohibit the direct expression of certain emotions. Patient resiliency in trying to make meaning of the adversity they experience by using their own cultural frameworks should be recognised and valued. To reduce stigma, or at least circumvent it, the practitioner may want to avoid using “psychiatric labelling” for some patients and involve the family/community key people in treatment when appropriate (Gearing et al., 2013). Clinicians



should consider the patient's point of view on health issues, including mental health, the family system, opinions on Western society, and the use of alternative modes of healing (Ciftci, Jones, & Corrigan, 2012)

## **6. Conclusions.**

The broad underlying question to this chapter has been whether migration results in poor health. Notwithstanding biases and methodological challenges in comparing the health of migrants with non-migrants, there is much to suggest that some health problems may arise following migration and that some health problems may be higher among migrants than among non-migrants. There is however no evidence to indicate that migration unambiguously causes poor health. What is certain is that the link between migration and health is not a straight forward and a linear one, but a complex one involving multiplicity of factors interacting with each other. Migration undoubtedly comes with a number of stressors; but, these stressors are not sufficient to account for all the observed (poor) health outcomes. Factors including personal factors (e.g. age, coping skills and resources, and genetic make-up) and factors existing within the country of origin and the country of settlement (e.g., the resettlement policies, and available and use of social support); the migration process itself (e.g., pre-migration preparation etc.) in their interaction with the stressors may either exacerbate vulnerabilities to poor health, or improve one's health. Any one of these factor in the course of the interaction tilt the balance between poor and good health. Furthermore, the migrant' illness explanatory model and that

of the attending practitioner, coupled with health services within the host society can affect the help seeking behavior, adherence to treatment and its outcome.

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